PRINTED: 04/07/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NVS2311AGC			B. WING		03/31/2009		
NAME OF PR	OVIDER OR SUPPLIER			RESS, CITY, STA			
ARCHO	F LAS VEGAS			TNING BAY C S, NV 89123	Т		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
Y 000	Initial Comments			Y 000			
	The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 3/31/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 6 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was 6. Six resident files were reviewed and 5 employee files were reviewed.						
Y 103 SS=D	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			Y 103			
	a separate personnel member of the staff o	e provided in subsection file must be kept for east a facility and must income ates required pursuant for the employee.	ach lude:				
	Based on record reviet failed to ensure 1 of 5 NAC 441A.375 regard (Employee #5) for the	ot met as evidenced by: ew on 3/31/09, the facil 5 caregivers complied w ding tuberculosis testing e protection of 6 of 6 11, #2, #3, #4, #5 and #	ity vith g				

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS2311AGC 03/31/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ARCHOFLAS VEGAS		9483 LIGHTNING BAY CT LAS VEGAS, NV 89123				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMAT		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE		
Y 103	Continued From page 1	Y 103				
	Severity: 2 Scope: 1					
Y 859 SS=F	449.274(5) Periodic Physical examination of resident	a Y 859				
	NAC 449.274 5. Before admission and each year after admission, or more frequently if there is a significant change in the physical condition or resident, the facility shall obtain the results of general physical examination of the resident his physician. The resident must be cared the pursuant to any instructions provided by the resident's physician.	of a by				
Y 870 SS=F	This Regulation is not met as evidenced by Based on record review on 3/31/09, the facil failed to ensure 4 of 6 residents received ar annual physical (Resident #1, #4, #5 and #6 Severity: 2 Scope: 3 449.2742(1)(a)(1)(2)(b)(c) 449.2742(1)(a)(1) Medication Administration	ity n).				
	NAC 449.2742 1. The administrator of a residential facility to provides assistance to residents in the administration of medications shall: (a) Ensure that a physician, pharmacist or registered nurse who does not have a finance.					

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Severity: 2

NAC 449.2742

Y 878

SS=E

Scope: 3

449.2742(6)(a)(1) Medication / Change order

Y 878

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		NVS2311AGC		B. WING		03/	/31/2009	
'			STREET ADD	RESS, CITY, STA	ATE, ZIP CODE			
A B C H OF LAS VEGAS		9483 LIGHTNING BAY CT LAS VEGAS, NV 89123						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
Y 878	Continued From page	e 3		Y 878				
	the physician. If a ph the amount or times in administered to a res	ntion prescribed by a Iministered as prescribe hysician orders a chang medication is to be ident: ponsible for assisting ir medication shall:	e in					
	Based on record revi the facility failed to er received medications #3 and #4).	ot met as evidenced by ew and interview on 3/3 nsure 3 of 6 residents as prescribed (Reside pe: 2	31/09,					
Y 936 SS=E	resident of a resident least 5 years after he facility. The file must that is resistant to fire unauthorized use. The records, letters, asses information and any of the resident, including	est be maintained for eartial facility and retained a permanently leaves the be kept locked in a place and is protected again the file must contain all assments, medical other information related without limitation: bliance with the provisions and the regulations	for at e cce ast	Y 936				
	This Regulation is no	ot met as evidenced by	:					

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